UNMC_WORDMARK_CMYK_pms187

COLLEGE OF NURSING

NEBRASKA’S HEALTH SCIENCE CENTER

**PRECEPTOR CREDENTIALS FORM**

The University of Nebraska Medical Center College of Nursing is required by our accrediting agency and the State Board of Nursing to document the credentials and professional experiences of persons who serve as preceptors with our students. Please complete the following information for our documentation. Thank you for your Involvement with our students.

|  |  |
| --- | --- |
| 1. Preceptor Name (include middle initial) |  |

|  |  |
| --- | --- |
| Credentials (RN, APRN, PA-C, MD etc.) |  |

|  |  |
| --- | --- |
| Specialty (Pediatrics, Family, Adult, Women’s, etc.) |  |
| *(Advanced practice preceptors only)* |  |

2. Current Employment

|  |  |
| --- | --- |
| Clinical Agency Name |  |

|  |  |
| --- | --- |
| Street Address |  |

|  |  |
| --- | --- |
| City, State, Zip |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Work Phone w/Area Code |  | Work Email |  |

|  |  |
| --- | --- |
| 3. Types of Patients (Acute, Chronic, In-Hospital, etc.) |  |
| *(Advanced practice preceptors only)* |  |

|  |  |
| --- | --- |
| 4. Number of Students Supervised Concurrently |  |

|  |  |  |
| --- | --- | --- |
| 5. *Undergraduate*: Number of years employed in nursing practice (2 year minimum required) |  | Yrs |
| *Graduate*: Number of years employed in advanced nursing practice (1 year minimum required) |  | Yrs |

6. Education. List all programs attended and degrees earned.

|  |  |  |  |
| --- | --- | --- | --- |
| University/Program | Location/State | Degree Granted | Date Granted (MM/YYYY) |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

7. List all current, valid licenses.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| State | Credentials (APRN, MD, etc) | License Number | Date Org License Granted | Expiration Date |
|  |  |  |  |  |
|  |  |  |  |  |

8. List all active certifications. *(Advanced practice preceptors only)*

|  |  |  |
| --- | --- | --- |
| Specialty Certification | Date of Original Certification | Expiration Date |
|  |  |  |
|  |  |  |
|  |  |  |

I have participated or will be participating in an orientation to the role and responsibilities of preceptor and I agree to provide information for use in the evaluation of the UNMC College of Nursing student. In addition, I agree to have this information placed in a database for the UNMC College of Nursing for current and future reference.

|  |  |  |  |
| --- | --- | --- | --- |
| Preceptor Signature |  | Date |  |

At your earliest opportunity, please send to Sarah Dawson at [sarah.dawson@unmc.edu](mailto:sarah.dawson@unmc.edu) or fax to 402-559-9666.